Maryland Health Enterprise Zone
Employer Hiring Tax Credit
24 Month Verification

Please fill out **one** form for **EACH** proposed "qualified position"

Attach copy of Final Certification Letter with the form.

1. Brief Description of the Position:

   _____

2. What type of qualified employee fulfills this position?

   ☐ HEZ Practitioner , Type: _____
   ☐ Interpreter
   ☐ Community Health Worker

3. Name of Qualified Employee: _____

4. Date Qualified Employee started at this position: _____

5. Has this employee been working, full-time in the Zone for 24 months? Yes ☐ No ☐

6. Addresses where the Qualified Employee works:

   Address 1:

   Address 2:

   Address 3:

7. Is this position still filled? Yes ☐ No ☐

   If No, please give the date the position became vacant: _____

8. What is the salary or hourly wage for this position? _____

9. Has this position had an impact on the establishment or expansion of services in the Health Enterprise Zone? Yes ☐ No ☐

10. Describe how this position has expanded access to services in the Health Enterprise Zone:

    _____
    _____
    _____

*An HEZ practitioner means a health care practitioner who is licensed or certified under the Health Occupations Article and who provides:
- Primary care, including obstetrics, gynecological services, pediatric services, or geriatric services;
- Behavioral health services, including mental health or alcohol and substance abuse services or;
- Dental Services

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Collection of Personal Information: In accordance with Executive Order 01.01.1983.18, the Department of Health and Mental Hygiene ("DHMH") advises you as follows: Certain personal information requested by the Department is necessary in determining your eligibility. Failure to disclose this information may result in the denial of one of these benefits or services. Availability of this information for public inspection is governed by the provisions of the Maryland Public Information Act, State Government Article, Sections 10-611 et seq. of the Annotated Code of Maryland. This information will be disclosed to appropriate staff of the Department and other public officials for purposes directly connected with administration of the program for which its use is intended. Such information is routinely shared with State, federal or local government agencies. You have the right to inspect, amend or correct personal records in accordance with the Maryland Public Information Act.

Publicity: The applicant agrees that DHMH may issue press releases and otherwise publicize information about the applicant's employment levels before and after its qualification for the Maryland Health Enterprise Zone Health Care Practitioner Personal Income Tax Credit.

Employment and Wage Data: Periodically the Office of Labor Market Analysis and Information of the Maryland Department of Labor, Licensing and Regulation ("DLLR"), in cooperation with the U. S. Department of Labor, Bureau of Labor Statistics ("BLS"), collects employment and wage data from you and other employers who conduct business in the State of Maryland. This information, collected on the Multiple Worksite Report (BLS 3020) and the Annual Refiling Survey (BLS 3023), is kept confidential and may only be used by DHMH with your written consent. DHMH is requesting disclosure of this information in order to evaluate the effectiveness of DHMH economic development programs and their impact on your company's employment level.

Consent: I give consent to DLLR to release the information that our company provides on the BLS 3023 form and the BLS 3020 form to DHMH, solely for the purpose of evaluating the effectiveness of the DHMH economic development programs and their impact on our company's employment level.

Attestation: I declare under the penalties of perjury, pursuant to Sec. 1-203 of the Tax-General Article, Annotate Code of Maryland, that this application (including any accompanying forms and statements) has been examined by me and the information contained herein, to the best of my knowledge and belief, is true, correct and complete. I understand that the Department may request at a later date additional information to verify the statements reported on this form, and that independent verifications of the information reported may be made.
Further, I hereby authorize the Social Security Administration, Comptroller of the Treasury, and Internal Revenue Service to release to the Department of Health and Mental Hygiene any and all information concerning the income or benefits received.

_____ By: _____
Date **Officer Signature**

Phone: _____ _____
Name (Print) and Title

Email: _____ _____
Business Name

Whom to contact for further information:	
Name (Print):	**Title:**
Phone:	**Email:**

Please return this application form to:

Roxanne Hale, Director OPCA
Health Systems and Infrastructure Administration
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21202